tation, the waiver is not cost-neutral, attach an explanation to Form HCFA-372(S) explaining why the waiver failed to demonstrate cost neutrality. You must then take action to amend its waiver for future years, and immediately correct the problem or the waiver may be terminated by HCFA. (See 42 CFR 441.304(d).) If a lag report is submitted, this section must also be completed.

5. *Section V (Subsections A-C).*—Section V reports other required data.

Subsection A.—Enter the total days of waivered coverage for all waiver individuals for each level of care in the approved waiver on line A.1. Compute the average length of stay by dividing the total days for each level of care by the number of waiver recipients for the level of care shown on line B.1. of section I. Enter the average length of stay for each level of care on line A.2. To be counted as a waiver recipient, an individual must have received one or more paid waiver services during the reporting period.

Include in these data all days as follows:

● Begin with the later of:

—The first day of waiver enrollment; *or*

—The first day of the reporting period.

● End with the earlier of:

—The last day of waiver program enrollment; *or*

—The last day of the reporting period.

This data may require updating to reflect lag data or adjustments, e.g., refunds, recoupments, cost settlements, or disallowances. Report the revised expenditures for acute care services provided to the waiver individuals in section V of a separate lag report. Indicate the prior period to which the revised data apply. Do not combine current and revised prior period data in a single report.

Subsection B.—A lag report is not required if you submit a complete initial report. If all data for that particular year is included on the initial Form HCFA-372(S), indicate that Form HCFA-372(S) is a complete report and thus no lag report is necessary. However, it is important to note that failure to submit timely Form HCFA-372(S) reports can result in a delay in approval of a State's amendment or renewal request.

Subsection C.—Check the appropriate boxes regarding the impact of the waiver on the health and welfare of waiver recipients and include the attachments indicated. If item 4 is not checked, items 5 and 6 must be checked and addressed. All other items must be checked and the specified information provided for acceptance of this section.

6. Certification.—

● *Signature: The individual in the State Medicaid agency who is certifying the information contained in this report.*

● *Title: The official title of the above individual.*

● *Date: Date the information is forwarded to HCFA.*

● *Contact Person: Enter the name of the individual to whom questions regarding this report should be addressed.*

● *Telephone Number: Enter the telephone number including the area code of the contact person.*

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0272. The time required to complete collecting this information is estimated to average 80 hours per response. This includes the time to review instructions, search existing data resources, gather the data needed, and to complete and review the information collected. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Health Care Financing Administration, P.O. Box 26684, Baltimore, Maryland 21207, and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

[¶ 150,050] Upper Price Limits for Prescription Drugs.

State Medicaid Manual, HCFA Pub. 45-6, Transmittal No. 35, July 1, 1998.

Medicaid: Payment for Drugs

Medicaid—Reimbursement in general—Drugs.—HCFA has issued a revised Addendum A to Part 6, Payment for Services, of its *State Medicaid Manual*. This addendum updates ingredient prices used by states and establishes upper limit prices for prescription drugs. The listings address

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multiple source drugs and take into consideration the addition of dispensing fees. Prices are generally based on 100 unit purchases. The revised addendum becomes effective Sept. 1, 1998.

See ¶ 14,723.29.

[Text of Transmittal]

[CCH Note: filing instructions have been omitted.]

CHANGED IMPLEMENTING INSTRUCTIONS—EFFECTIVE DATE: 9/1/98

Addendum A, updates ingredient prices used by States to establish upper limits for prescription drugs under 42 CFR 447.332 and § 1927(e) of the Social Security Act.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

[Text of Revision]

[CCH Note: revised text will appear in the CCH electronic HCFA Manuals database.]

[¶ 150,051] Revisions to ESRD Network Organization Manual.

End Stage Renal Disease Network Organizations Manual, HCFA Pub. 81, Transmittal No. 7, July 1, 1998.

Medicare: Conditions of Participation

Provider agreements—Conditions of participation—Requirements for ESRDs.—HCFA has modified the names of some topics in the *ESRD Network Organizations Manual*. "Contract Administration" has been deleted from Part 3 and "Confidentiality and Disclosure" put in its place. In Part 4, "Data and Reports" has become "Information Management." Similar changes in section titles occur throughout the manual. Thirty-two sections in Parts 1, 2, and 3 exhibit revisions. Changes to Part 1 include updates to the ESRD network's statement of purpose and requirements; revisions to Part 2 define the organizational structure and quality control programs; and changes to Part 3 discuss confidentiality and disclosure provisions.

See ¶ 12,620, ¶ 12,640.

[Text of Transmittal]

[CCH Note: filing instructions have been omitted.]

CHANGED PROCEDURES—EFFECTIVE DATE: SEPTEMBER 9, 1998

In this instruction the Table of Contents has been revised to delete "Contract Administration" from Part 3 and insert "Confidentiality and Disclosure." Previously, title changes were made in Part 4 from "Data and Reports" to "Information Management," in Part 5 from "Quality Assurance" to "Quality Improvement," in Part 6 from "Community Outreach" to "Community Information and Resource," and in Part 7 from "Sanctions," to "Sanctions and ESRD Grievances." New tabs for the Table of Contents were printed and distributed.

Part 1, Background and Responsibilities, has been revised to include Network organization background, goals, and role in the Health Care Quality Improvement Program, to delete sections relating to HCFA's role, and the responsibilities of the regional office project officer.

Section 100, Authority, states the statutory and regulatory authority for the ESRD Network Organizations.

Section 110, Purpose of ESRD Network Organizations, describes the statutory authority for Networks and the purpose delineated by that authority.

Section 115, Requirements for ESRD Network Organizations, describes requirements for establishing ESRD Networks.

Section 120, Responsibilities of ESRD Network Organizations, lists functions the Networks are to perform.

Section 125, Health Care Quality Improvement Program (HCQIP), describes a process which monitors program performance.

Section 130, Goals, describes the national goals of the ESRD Network program.

Section 135, Network Organization's Role in HCQIP, describes the Network's role in conducting quality improvement activities.

CHANGED PROCEDURES—EFFECTIVE DATE: SEPTEMBER 9, 1998

The Title of Part 2 is changed from "Eligibility" to "Administration" to reflect the administrative responsibilities of the Networks.

NEW PROCEDURES—EFFECTIVE DATE: SEPTEMBER 9, 1998

Section 200, Organizational Structure, describes the Networks organizational structure and basic administrative staff.